(4)

No. 87-1097

In the Supreme Court of the United States

OCTOBER TERM, 1987

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

GEORGETOWN UNIVERSITY HOSPITAL, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

JOINT APPENDIX

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PETITION FOR A WRIT OF CERTIORARI FILED DECEMBER 30, 1987
CERTIORARI GRANTED FEBRUARY 29, 1988

82 pp

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* The opinion, judgment, and orders of the court of appeals and opinion and order of the district court are printed in the appendix to the petition for a writ of certiorari and have not been reproduced here.

CONTENTS – Continued

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

Nos. 86-5381, 86-5382, 86-5383
(consolidated cases)

RELEVANT DOCKET ENTRIES

Date	Filings – Proceedings
(B)06-20-86	Copy of notice of appeal and docket entries from Clerk, DC (n-2)
(R)06-23-86	Notice from Clerk, DC re: Motion by deft. to continue stay, pending appeal of the Court's Order dated 4-11-86 [15].
(R)07-01-86	Notice from Clerk, DC re: order filed 6-24-86 [15].
(R)09-16-86	5 – Appellant's motion to consolidate case #86-5381, 86-5382 and 86-5383 (m-16) [13].
(E)09-25-86	The motion to consolidate is granted.
(R)10-22-86	15 – APPELLANT'S BRIEF (m-22) 35.5.
(R)10-22-86	7 – APPELLANT'S APPENDIX (m-22).
(X)01-16-87	16 – APPELLEES' BRIEF (p-16) (25).
(X)02-20-87	15 – APPELLANT'S REPLY BRIEF (m-20) (25).
(W)03-12-87	CERTIFIED ORIGINAL RECORD, 1 Volume, 1 Reporters Transcript under 1 cover, 1 Administrative Record to #7

Date	Filings – Proceedings
	in Brown Folder and Supplemental Record #30 Notice of Filing – *Placed Under Seal* in 2 brown envelopes.
(X)03-24-87	15 – APPELLEES' SUPPLEMENTAL BRIEF (m23) (25).
(W)03-30-87	ARGUED before Edwards, Starr, CJs and Luther M. Swygert, Senior Circuit Judge, U.S. Court of Appeals for the Seventh Circuit. [Bin #54-2].
(X)03-31-87	5 – Letter from counsel for appellant advising of additional authorities pursuant to FRAP 28(j) (m-31) (25).
(X)04-03-87	5 – Letter from counsel for appellee in response to appellant's letter dated 3/31/87 (p-3) (25).
(X)04-21-87	5 – Letter from counsel for appellee advising of additional authorities pursuant to FRAP 28(j) (p-21) (25).
(X)05-13-87	5 – Letter from counsel for appellee advising of additional authorities pursuant to FRAP 28(j) (p-13) (25).
(X)05-14-87	4 – Corrected letter from counsel for appellee advising of additional authorities pursuant to FRAP 28(j) (p-13) (25).
(X)06-02-87	5 – Letter from counsel for appellant advising of additional authorities pursuant to FRAP 28(j) (p-2) (25).
(X)06-08-87	5 – Letter from counsel for appellee in response to 28(j) letter filed 6/2/87 (p-8) (25).

Date	Filings – Proceedings
(X)06-09-87	5 – Letter from counsel for appellant advising of additional authorities pursuant to FRAP 28(j) (p-9) (25).
(X)06-10-87	5 – Letter from counsel for appellee in response to 28(j) letter filed 6/9/87 (p-10) (25).
(X)06-24-87	5 – Letter from counsel for appellant advising of additional authorities pursuant to FRAP 28(j) (p-24) (25).
(D)06-26-87	Opinion for the Court filed by Circuit Judge Edwards.
(D)06-26-87	Judgment by this Court that the judgement of the District Court appealed from in these causes is hereby affirmed, in accordance with the Opinion for the Court filed herein this date.
(D)06-26-87	Mandate order.
(R)07-10-87	5 – Appellee's bill of costs (m-10) [9].
(R)08-10-87	20 – Appellant's petition for rehearing and suggestion for rehearing en banc (m-10) [1].
(J)09-01-07	Per Curiam order denying appellant's petition for rehearing. Edwards, Starr, CJs and Sygert, SCJ, U.S. Court of Appeals for the Seventh Circuit.
(J)09-01-87	Per Curiam order en banc denying appellant's suggestion for rehearing en banc. CJ Wald, Robinson, Mikva, Edwards, Ruth B. Ginsburg, Bork, Starr, Silberman, Buckley, Williams and D.H. Ginsburg, and Swygert, SCJ, U.S. Court of Appeals for the Seventh Circuit.

Date	Filings – Proceedings
(D)10-05-87	MANDATE ISSUED. Costs are awarded to appellees in the amount of $265.85 and taxed against Otis R. Bowen, Secretary of HHS.
(R)01-12-88	Notice from Clerk, Supreme Court advising that petition for certiorari was filed in Supreme Court #87-1097 on 12-30-87 [1].

UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA

No. 85-1845

GEORGETOWN UNIVERSITY HOSPITAL, ET AL.,
PLAINTIFFS

v.

HECKLER, DEFENDANT

RELEVANT DOCKET ENTRIES

Date	NR	Proceedings
1985		
June 6	1	COMPLAINT; appearance. (br)
June 6		SUMMONS (1) issued.
Aug. 5	6	ANSWER by deft. to complaint. (br.)
Aug. 5	7	NOTICE of Filing by deft.; ADMINISTRATIVE RECORD: (3 vols). (br.)
Aug. 7		CALENDERED. CD/N. (br.)
Aug. 19	9	MOTION by plntfs to compel (filed 8/16/86); memo; exhibit 1-4. (hls)
Sept. 5	11	MEMORANDUM by dft in opposition to plntfs' motion to compel; exhibit A-C. (hls)
Sep. 13	12	REPLY by plntfs. to deft's opposition to plntfs.' motion to compel. (df).
Sep. 20	13	RESPONSE by deft. to the Court's suggestion that the withheld documents be submitted to the Court and placed under seal, or in the alternative, that

Date	NR	Proceedings
		such records be retained by deft. under court order. (df)
Sep. 27	14	MEMORANDUM filed 9-23-85 (signed 9-22-85) (N). OBERDORFER, J. (df)
Sep. 27	15	ORDER filed 9-23-85 directing deft. file by 9-30-85 under seal all documents listed in administrative record in Sutter v. Dept. of Health and Human Services, No. 85-1118; directing parties file dispositive motions by 10-21-85; directing responses to motions be filed by 11-4-85. (signed 7-22-85) (N). OBERDORFER, J. (df)
Oct. 4	29	FILING of documents under seal by deft; attachment. (hls)
Oct. 4	30	NOTICE by deft of filing; declaration of Henry Desmarais, MD; attachments; (filed under seal-vault 1800, 2 vols). (hls)
Oct. 21	32	MOTION by pltfs for summary judgment; statement of material facts; memo; table of contents; exhibits 1-7. (hls)
Oct. 21	33	MOTION by deft for summary judgment; P&A; table of contents; table of authorities. (hls)
Nov. 4	35	ORDER consolidating CA 85-2545, 85-2862, WITH 85-1845. (hs)
Nov. 12	36	DEFT'S reply brief. (hls)

Date	NR	Proceedings
Nov. 12	37	MEMORANDUM of pltfs in opposition to deft's motion for summary judgment and in further support of pltfs' motion for summary judgment; table of contents; table of authorities; Exhibits 11 thru 13. (io).
Nov. 18		CROSS MOTIONS for summary judgment argued and taken under advisement. (Rep: T. Dourian) Oberdorfer, J. (io)
Dec. 2	38	POST-HEARING MEMORANDUM of pltfs; Exhibits 1 thru 48; (Rep: Thomas Dourian) (io)
Dec. 16	39	TRANSCRIPT OF PROCEEDINGS from 11-18-85; pages 1 thru 48; (Rep: Thomas Dourian) (io)
Dec. 18	40	RESPONSE of deft to pltfs' post hearing memorandum. (io)
1986		
Apr. 14	41	MEMORANDUM (filed 4-11-86). (N) Oberdorfer, J. (io)
Apr. 14	42	ORDER filed 4-11-86 granting pltfs' motion for summary judgment; denying deft's motion for summary judgment; and directing that on or before 4-25-86 deft pay to pltfs amounts previously recouped from pltfs, plus interest. (N) Oberdorfer, J. (io)
Apr. 24	46	ORDER granting deft's motion to stay Court's order of 4-11-86; staying

Date	NR	Proceedings
		Court's order and judgment of 4-11-86 until ten (10) days after the period of time for filing of notice of appeal is exhausted. (N) Oberdorfer, J. (io)
June 6	47	NOTICE OF APPEAL by deft Otis R. Bowen, M.D. from order entered 4-11-86. No fee paid, U.S. Government. Copies mailed to: Ronald N. Sutter. (io)
June 11		PRELIMINARY RECORD transmitted to USCA; USCA #86-5381. (io)
June 30	49	ORDER filed 6-24-86 staying Court's Order & Judgment of 4-11-86 until ten (10) days after appeal is resolved. (N) USCA/N Oberdorfer, J.

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

No. 85-2545

HOWARD UNIVERSITY, ET AL., PLAINTIFFS

v.

HECKLER, DEFENDANT

RELEVANT DOCKET ENTRIES

Date	NR	Proceedings
1985		
Aug. 9	1	COMPLAINT, appearance. (sl)
Aug. 9		SUMMONS (3) issued. (sl)
Oct. 9	2	ANSWER by deft to complaint. (hls)
Oct. 11	3	NOTICE by deft of filing of administrative record. (hls)
Oct. 17		CALENDERED. CD/N (hls)
Oct. 21	5	MOTION by pltfs for summary judgment. (hls)
Nov. 1		STATUS CALL: oral motion of pltf to consolidated CA 85-1845 and CA 85-2862 with CA 2545 argued and granted.
Nov. 6	6	MOTION by deft for summary judgment. (hls)
Nov. 4	7	ORDER consolidating CA 85-2545, 85-2862 with 85-1845. (hls)

Date	NR	Proceedings
Nov. 12		MEMORANDUM of pltfs in opposition to deft's motion for summary judgment and in further support of pltfs' motion for summary judgment; table of contents; table of authorities; Exhibits 11 thru 13. (filed in 85-1845) (io)
Nov. 18		CROSS MOTIONS for summary judgment argued and taken under advisement (Rep: Tom Dourian) Oberdorfer, J. (io)
Dec. 2		POST-HEARING MEMORANDUM of pltfs; Exhibits 1 thru 3. (filed in 85-1845) (io)
Dec. 16		TRANSCRIPT OF PROCEEDINGS from 11-18-85; pages 1 thru 48; (Rep: Thomas Dourian) filed in 85-1845) (io)
1986		
Apr. 14	8	MEMORANDUM (filed 4-11-86). (N) Oberdorfer, J. (Orig. filed in 85-1845) (io)
Apr. 14	9	ORDER filed 4-11-86 granting pltfs' motion for summary judgment; denying deft's motion for summary judgment; and directing that on or before 4-25-86 deft pay to plfts amount previously recouped from pltfs, plus interest. (N) Oberdorfer, J. (Orig. filed in 85-1845) (io)
Apr. 24	10	ORDER granting deft's motion to stay Court's order of 4-11-86; staying Court's order and judgment of 4-11-86 until ten (10) days after the period of time for filing of notice of appeal is exhausted. (N) Oberdorfer, J. (Orig. filed in 85-1845) (io)
Jun. 6	11	NOTICE OF APPEALS by deft Otis R. Bowen, M.D. from order entered 4-11-86. No fee paid, U.S. Government. Copies mailed to: Ronald N. Sutter. (io)
Jun. 11		PRELIMINARY RECORD transmitted to USCA; #86-5382. (io)
Jun. 30		ORDER filed 6-24-86 staying Court's Order & Judgment of 4-11-86 until ten (10) days after appeal is resolved. (N) (USCA.N) (filed in CA 85-1845) Oberdorfer, J. (1a)

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

No. 85-2862

TUCSON GENERAL HOSPITAL, PLAINTIFF

v.

HECKLER, DEFENDANT

RELEVANT DOCKET ENTRIES

Date	NR	Proceedings
1985		
Sept. 9	1	COMPLAINT; appearance; Attachment. (mao)
Sept. 9		SUMMONS (3) issued. (mao)
Oct. 21	2	MOTION by pltf. for summary judgment. (ks)
Nov. 6	3	ANSWER by deft. to the complaint. (ks)
Nov. 6	4	NOTICE by deft. of filing the Administrative Record. (ks)
Nov. 6	5	MOTION by deft. for summary judgment. (ks)
Nov. 15	6	ORDER FILED 11-4-85 consolidating CA 85-2545 and CA 85-2862 with CA 85-1845. (ks)
Nov. 12		MEMORANDUM of pltfs in opposition to deft's motion for summary judgment and in further support of pltfs' motion for summary judgment;

Date	NR	Proceedings
		table of contents; table of authorities; Exhibits 11 thru 13. (filed in 85-1845) (io)
Nov. 18		CROSS MOTIONS for summary judgment argued and taken under advisement. (Rep. T. Dourian) Oberdorfer, J. (io)
Dec. 2		POST-HEARING MEMORANDUM of pltfs; Exhibits 1 thru 3. (filed in 85-1845) (io)
Dec. 16		TRANSCRIPT OF PROCEEDINGS from 11-18-85; pages 1 thru 48; (Rep: Thomas Dourian) (filed in 85-1845) (io)
1986		
Apr. 14	7	MEMORANDUM (filed 4-11-86). (N) Oberdorfer, J. (Orig. filed in 85-1845)
Apr. 14	8	ORDER filed 4-11-86 granting pltfs' motion for summary judgment; and directing that on or before 4-25-86 deft pay to pltfs amounts previously recouped from pltfs, plus interest. (N) Oberdorfer, J. (Orig. filed in 85-1845) (io)
Apr. 24	9	ORDER granting deft's motion to stay Court's order of 4-11-86; staying Court's order and judgment of 4-11-86 until ten (10) days after the period of time for filing of notice of appeal is exhausted. (N) Oberdorfer, J. (Orig. filed in 85-1845) (io)

Date	NR	Proceedings
Jun. 6	10	NOTICE OF APPEALS by deft Otis R. Bowen, M.D. from order entered 4-11-86. No fee paid, U.S. Government. Copies mailed to: Ronald N. Sutter. (io)
Jun. 11		PRELIMINARY RECORD transmitted to USCA; USCA #86-5383. (io)
Jun. 30		ORDER filed 6-24-86 staying Court's Order & Judgment of 4-11-86 until ten (10) days after appeal is resolved. (N) (USCA/N (filed in CA 85-1845) Oberdorfer, J. (1a)

49 Fed. Reg. 6175-6180 (1984)

Health Care Financing Administration

Medicare Program; Reissuance of the Wage Index in the 1981 Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed notice.

SUMMARY: We are reissuing for public comment the change in the types of data that were used to calculate the wage index that was contained in the schedules of limits on hospital per diem inpatient general routine operating costs reimbursable under Medicare that were applicable to cost reporting periods beginning on or after July 1, 1981 and for cost reporting periods ending after September 30, 1981. The cost limits for cost reporting periods beginning on or after October 1, 1982 are governed by the notice published in the **Federal Register** on September 30, 1982 (47 FR 43296) and August 30, 1983 (48 FR 39426) and are not affected by this reissuance. The wage index was originally issued as part of the schedule of limits published on June 30, 1981 (46 FR 33637) and September 30, 1981 (46 FR 48010) and is being reissued as the result of the April 29, 1983 decision of the United States District Court for the District of Columbia in the case of *District of Columbia Hospital Association, et al. v. Heckler, et al.* (No. 82-2520 DDC). The District Court held that the 1981 schedule of hospital cost limits was invalid for failure to comply with the Administrative Procedure Act insofar as the schedule incorporated or was formulated by using a wage index that was calculated by excluding Federal government hospital wage data.

DATES: To assure consideration comments must be received by March 19, 1984.

ADDRESS: Address comments in writing to: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-276-P, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to Room 309-G Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C., or to Room 132, East Hight Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207. In commenting, please refer to BERC-276-P.

Comments will be available for public inspection as they are received, beginning approximately three weeks from today, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, D.C. 20201, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (Phone: 202-245-7890)

FOR FURTHER INFORMATION CONTACT:
Marilyn Koch, 301-594-9343.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) as amended by Section 223 of Pub. L. 92-603, the Social Security Amendments of 1972, authorizes the Secretary to set prospective limits on the costs that are reimbursed under Medicare. These limits may be applied to direct or indirect overall costs or to costs incurred for specific items or services furnished by a Medicare provider, and may be based on estimates of the cost necessary for the efficient delivery of needed health services.

Regulations implementing this authority are set forth at 42 CFR 405.460. Under this authority, we published limits on hospital per diem inpatient general routine service costs

annually from 1974 through 1978, and limits on hospital per diem inpatient general routine operating costs in 1979, 1980, and 1981.

On June 30, 1981, we published in the **Federal Register** (46 FR 33637) a schedule of limits on hospital per diem inpatient general routine operating costs applicable to cost reporting periods beginning on or after July 1, 1981. A revised schedule of limits incorporating changes made by the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 96-499) was published on September 30, 1981, (46 FR 48010), effective for cost reporting periods ending after September 30, 1981. For cost reporting periods that began before October 1, 1981, the limits in the September 30, 1981 notice applied only to the portion of the cost reporting period that occurred after September 30, 1981. In these notices, we described the scope of the cost limits and explained our methodology for deriving and applying the limits.

The June 30, 1981, notice (46 FR 33637) was published as a final notice without a prior notice and comment period. In the preamble to that notice, we stated that "in developing the revised limits, we followed the same methodology we used to develop the current limits," except for "minor technical changes in the types of data we used to calculate the wage index and the market basket values." The preamble went on to state that data from Federal government hospitals were excluded from the wage index to improve the accuracy of the wage index adjustment because Federal hospitals typically use national pay scales that do not necessarily reflect area wage levels (46 FR 33699). We determined that, while this wage adjustment would negatively affect only a few hospitals in only a relatively few standard metropolitan statistical areas (SMSAs), it would prevent an unwarranted distribution of public funds to certain hospitals and also prevent

the distorting effect of Federal wage scales on the entire wage index. Thus, we determined that use of the notice and comment procedures of the Administrative Procedure Act (APA) with respect to the calculation of the wage index was both unnecessary and contrary to the public interest. We therefore concluded that under the good cause exceptin of 5 U.S.C. 553(b)(B) of the APA, there was adequate justification to waive these procedures.

On April 29, 1983, the District Court for the District of Columbia in the case of *District of Columbia Hospital Association, et al v. Heckler, et al* (No. 82-2520 DDC) declared the exclusion of Federal hospital wage data from the wage index without prior notice and comment to be a violation of the APA. The court declared invalid the 1981 hospital cost limit schedule insofar as it incorporated or was formulated by using a hospital wage index that excluded Federal government hospital data. As part of this decision on April 29, 1983, the District Court for the District of Columbia ordered us to publish a notice in the **Federal Register** stating that the 1981 schedule of hospital cost limits had been declared invalid with respect to the wage index. We published this notice in the **Federal Register** on September 2, 1983 (48 FR 39998).

The purpose of the reissuance of the wage index as set forth below, is to seek public comments solely on the exclusion of Federal government hospital wage data from the index. All other aspects of the cost limit methodology, as published in the June 30, 1981 (46 FR 33637) and September 30, 1981 (46 FR 48010) notices, remain in effect and unchanged.

II. Explanation of the Wage Index Methodology

The use of the wage index as one component in the setting of cost limits was first introduced in 1979 to replace

per capita income as an indicator of area variations in wage levels. In developing the cost limit schedules for the June 30, 1981 and September 30, 1981 notices, we used a hospital wage index to reflect area-by-area differences in the labor-related component of hospital costs (wages and salaries, employee benefits, professional fees, costs of business services, and other miscellaneous expenses). We developed this index from hospital wage data obtained from the Bureau of Labor Statistics (BLS). The data used are those for the "hospital industry," a standard BLS reporting category. The wage index we used for the limits in the June 30, 1981 and September 30, 1981 notices was based on data for calendar year 1979, which were the lastest available data. We have used the same data for this proposed reissued wage index.

To calculate this index, we first computed the average hospital wage for each Standard Metropolitan Statistical Area (SMSA) or New England County Metropolitan Area (NECMA) and non-SMSA/non-NECMA. We then calculated the national average hospital wages for all SMSAs or NECMAs, and a separate national average hospital wage for all non-SMSAs/non-NECMAs. We then divided the average wage level for each area by the appropriate national average (SMSA/NECMA or non-SMSA/non-NECMA). These calculations resulted in an index value for each SMSA or NECMA that reflects the wage level for that area relative to the national average for all SMSAs/NECMAs, and an index value for each non-SMSA/non-NECMA that reflects the wage level for that area relative to the national average for all non-SMSAs/non-NECMAs (see Table 1A and 1B).

In addition to being based on more current data, the wage index we used in the June 30, 1981 and September 30, 1981 notices differed in two ways from the wage index used in developing the 1980 hospital cost limits. First, we

used approximate rather than actual index values for 26 areas. (These approximate values are identified by asterisks in Table IA). We made this change because the BLS, which supplies the data on wages and numbers of employees that we use to calculate the wage index, informed us that its confidentiality requirements prohibited it from disclosing actual data for areas that included fewer than three reporting units. (A reporting unit need not have been a single hospital. Reporting unit was (and is currently) defined by the BLS as the smallest unit for which data are recorded on the employer's contribution report. For example, two facilities in the same area owned by one employer could have appeared as one reporting unit.)

To make it possible to calculate limits for these areas, we asked the BLS to identify the areas having wage index values numerically closest to, but not less than, the areas for which it could not supply actual data. In the case of each area for which actual data were unavailable, we substituted the wage index value identified by the BLS as being closest to the actual value. We stated our belief that the use of approximate rather than actual values for these areas would not affect the accuracy of the limit significantly, and would assure that no hospital's limit was reduced because actual data for its areas were unavailable.

Second, in developing the wage index used for the limits in the June 30, 1981 and September 30, 1981 notices, we excluded data from Federal government hospitals. In this proposed reissuance of the 1981 wage index, we are continuing to exclude data from Federal hospitals from the wage data.

As a result of prior schedules that were issued, we received correspondence concerning the inequity of including Federal hospital wages in developing the wage index. We examined this issue and found that including Federal hospital wages resulted in wage index values that

were unrealistically low in areas without Federal hospitals in comparison to adjacent areas with Federal hospitals. The reason for this is that including Federal hospital wages in the data raises the national average hospital wage for all SMSAs/NECMAs and the national average hospital wage for all non-SMSAs/non-NECMAs. However, in determining the wage index for an adjacent area, the area's average wage would be divided by this higher national average resulting in a lower wage index. Yet these adjacent areas with an unrealistically low wage index were competing for the same employees as those areas whose only difference in average wages was the fact that a Federal hospital was located in the SMSA or non-SMSA. Including Federal hospital wage data resulted in wage indexes that did not reflect the differences in wages from area to area. Therefore, in order to correct this inaccuracy, we excluded Federal hospital data from the 1981 wage index.

The exclusion of Federal hospital data is technical in nature. It is designed to improve the accuracy of the wage index so that the index accurately reflects actual differences in wages from one area to another area. It is the purpose of hospital limits to ensure that the Medicare program reimburses providers only for those costs necessary in the efficient delivery of needed health services (42 U.S.C. 1395x(v)(1)(A)). The hospital wage index is but one component of the methodology used to establish limits on hospital inpatient routine operating costs. The wage index serves to reflect area-by-area differences in the labor related component of hospital costs. The more accurate the wage index, the more accurately it reflects these area-by-area differences and thus, ultimately, the more accurate the cost limits. In turn, this means that in accordance with Congressional intent, reimbursement is limited to those costs necessary in the efficient delivery of services.

Therefore, we believe that in 1981 we were correct in improving the accuracy of the hospital wage index by excluding the wage data of Federal government hospitals. We concluded that the exclusion of Federal government hospital data would improve the accuracy of the wage index because most Federal hospitals characteristically employ physicians and other high salaried professionals whose salaries are based on national rather than local wage scales. This factor tends to overstate the average hospital wage in areas with Federal institutions as compared to areas without such Federal facilities. Since the purpose of the wage index is to reflect area-by-area differences in the labor-related component of hospital costs, the exclusion of Federal hospital data better enables the wage index to accurately reflect area-by-area labor-related costs.

To the extent hospitals must pay employees wage rates similar to those of Federal facilities to attract qualified personnel, this competitive behavior is reflected in the non-Federal BLS data used to calculate the wage index. That is, if non-Federal hospitals in an area pay wage rates relatively equivalent with those of Federal hospitals, the exclusion of Federal wages would have little effect on the wage index. If wages paid to Federal hospital employees are higher than most area hospital wage levels, then the inclusion of Federal data results in most hospitals receiving a higher Medicare cost limit than is warranted based on their expected costs. Such a result defeats the purpose of the cost limits, which is to limit a provider's reimbursement to only those costs necessary in the efficient delivery of needed health services. Therefore, reissuance of the wage index excluding Federal hospital data reflects Congressional intent to limit hospital reimbursement to those costs necessary in the efficient delivery of services.

The reissuance of the wage index excluding Federal hospital data also avoids placing an unwarranted hardship and burden on intermediaries and many hospitals, while it would impose only a minimal burden on a few hospitals. The inclusion of Federal data in the wage index at this point in time would result in overpayments to many hospitals. As explained previously if we were to include Federal data now, we would have to recompute the national average hospital wage for all SMSAs or NECMAs and the national average hospital wage for all non-SMSAs/non-NECMAs. Both of these averages would be higher if the Federal hospital wage data were included. If the average wage level in an area without Federal hospitals were divided by the recomputed higher national average hospital wage, a lower wage index would result for that area. In this case, we would instruct the intermediaries to recompute the cost limits for those hospitals in areas with revised wage indexes and to recoup any overpayments that would result from the recomputation of the cost limits. We realize that this would create a hardship and burden on both hospitals and intermediaries. Intermediaries would have to review and revise already settled cost reports and reissue notices of program reimbursement (NPRs). Hospitals would be faced with overpayments as the result of these revised cost reports and may have to borrow money to repay the government. In contrast, those few hospitals that would receive less reimbursement if Federal hospital data are excluded from the wage index would not be unduly harmed or burdened by the reissuance of the wage index since these hospitals could only have relied on the wage index as published on June 30, 1981 and September 30, 1981 for reimbursement purposes. Since these limits are prospectively established and published in advance, all hospitals knew before the beginning of their respective cost reporting periods what their cost limit

would be. No hospital could have reasonably relied on a wage index that included Federal hospital data after the June 30, 1981 **Federal Register** notice. No hospital nor intermediary would be unduly harmed by this reissuance of the wage index. This proposed notice would simply put the previously set cost limits back into effect.

In summary, we believe that the exclusion of Federal hospital data from the wage index more accurately reflects actual hospital experience. We wish to note that the data used to develop the wage index were supplied by the BLS, and are the most reliable data available: All hospitals are required under State unemployment compensation laws to report these data. If we discover that we or the BLS have made an error based on data received from hospitals that results in an incorrect wage index for any area, we will publish corrected indexes in the **Federal Register** and will direct the Medicare intermediaries to recalculate the limits. However, the BLS has advised us that they are unable to correct any inaccuracies in the wage index that may result from a hospital's failure to report the required wage data.

It should be noted that from the time the original notice was published on June 30, 1981, BLS has advised us of various reporting errors in the wage and employment data. In addition on June 19, 1981, the Office of Management and Budget (OMB) announced the designation of new SMSAs and NECMAs as well as revisions in the metropolitan classifications based on the results of the 1980 census. We have issued instructions to the intermediaries advising them of these changes. However, in those situations where the corrected data resulted in a lower wage indexes for an area, we continued to use the higher wage index. The wage index which are shown in Tables I-A and I-B reflect the corrections that have been made since June 30, 1981.

III. Impact Analyses

A. Executive Order 12291 and Regulatory Flexibility Act

Executive Order 12291 requires us to prepare and publish a regulatory impact analyses for any regulations that are likely to have an annual effect on the economy of $100 million or more, cause a major increase in costs or prices, or meet other threshold criteria that are specified in that order. In addition, the Regulatory Flexibility Act (Pub. L. 96-354) requires us to prepare and publish a regulatory flexibility analyses for regulations unless the Secretary certifies that the regulations will not have a significant economic impact on a substantial number of small entities. (For purposes of the Regulatory Flexibility Act, small entities include all nonprofit and most for-profit hospitals.) Under both the Executive Order and the Regulatory Flexibility Act, such analyses must, when prepared, show that the agency issuing the regulations has examined alternatives that might minimize unnecessary burden or otherwise ensure the regulations to be cost-effective.

We have determined that this proposed notice, if implemented, would not meet the criteria of either E.O. 12291 or the Regulatory Flexibility Act. We considered two alternatives:

- To republish area wage indexes calculated as published in [illegible] with no change in methodology; or
- To [illegible]sh area wage indexes recalculated to incorporate Federal hospitals in the base data.

In the process of reviewing these alternatives, we considered their comparative impacts on hospital cost reporting periods subject to the cost limits published in 1981. We found that if we included Federal hospitals in the area wage index determinations, we would have to recalculate

both urban SMSAs/NECMAs and rural national average hospital wage levels, as well as the means used to determine the per diem limits for each group (published as Tables I and II in the 1981 notices). This would affect the limit for every hospital subject to the limits, although only to a relatively small degree. The limits for some groups would increase, while the limits for other groups would decrease.

The effect on a particular hospital would be the result of multiplying the per diem limit for the hospital's group by the hospital's revised area wage index. If both the limit and index for a hospital increased or decreased, the effect would of course be mutiplied, while if they moved in opposite directions, the changes would tend to cancel out.

We determined that the net effect on overall program expenditures would be relatively small, due to the tendency of increases and decreases in limits and indexes to cancel each other out in the aggregate. A change of area wage indexes to incorporate Federal hospitals in the base data would have the primary effect of redistributing marginal advantages and disadvantages. However, if Federal wages were included, more hospitals would be adversely affected, although the impact on the majority of individual hospitals would be relatively small. Including Federal hospital wage data would benefit those few hospitals located in an area with Federal hospital employees. We estimate that very few hospitals would have their annual reimbursement affected by more than $5,000. In the aggregate, the reissuance of wage indexes excluding Federal hospitals would result in smaller net disadvantage to hospitals as a whole, and is more cost beneficial to the hospitals.

Since the use of the wage index methodology as initially published in 1981 does not meet any of the criteria for identifying a major rule under E.O. 12291, we have determined that this notice is not a major rule and that a regulatory impact analysis is not required. In addition, the Secretary certifies under section 603(b) of the Regulatory Flexibility Act, that this notice will not result in a significant economic impact on a substantial number of small entities, and that a regulatory flexibility analysis is not required.

B. Paperwork Burden

This notice contains no information collection requirements, and therefore, is not subject to review by the Office of Management and budget [sic] under the Paperwork Reduction Act of 1980 (44 U.S.C. 3507).

IV. Wage Index Tables

TABLE I-A.—WAGE INDEX FOR URBAN AREAS

SMSA area	Wage index
Abilene, TX	[6]0.8485
Akron, OH	[6]1.0417
Albany, GA	[6].8566
Albany-Schenectady-Troy, NY	.9624
Albuquerque, MN	[6]1.0009
Alexandria, LA	[5].9218
Allentown-Bethlehem-Easton, PA-NJ	[6]1.0569
Altoona, PA	1.0219
Amarillo, TX	.9233
Anaheim-Santa Ana-Garden Grove, CA	[6]1.2115
Anchorage, AK	[6]1.6461
Anderson, IN	[6].9812

* * *

[remainder of tables not reproduced]

Sec. 1102, 1814(b), 1861(v)(1), 1866(a), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395x(v)(1), 1395cc(a), 1395hh, and 42 CFR 405.460)

Dated: November 17, 1983

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: February 8, 1984.

Margaret M. Heckler,

Secretary.

49 Fed. Reg. 46495-464501 (1984)

Health Care Financing Administration

(BERC-276-FN)

Medicare Program; Reissuance of the Wage Index in the 1981 Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final notice.

SUMMARY: This notice affirms the use of the wage index that was used to calculate the 1981 schedule of limits on hospital per diem inpatient general routine operating costs, which was issued on June 30, 1981 (46 FR 33637), and September 30, 1981 (46 FR 48010). The 1981 wage index was reissued for public comment on February 17, 1984 (49 FR 6175).

EFFECTIVE DATE: This notice is effective December 26, 1984. It applies to cost reporting periods beginning on or after July 1, 1981, and cost reporting periods ending after September 30, 1981, as well as cost reporting periods beginning on or after October 1, 1981, and before October 1, 1982.

FOR FURTHER INFORMATION CONTACT:
Maureen McGrath, 301-594-7373.

SUPPLEMENTARY INFORMATION:

I. Background

In the **Federal Register** on February 17, 1984 (49 FR 6175), we described for public comment a change in the types of data that were used to calculate the wage index that was contained in the notices on the schedule of limits on hospital per diem inpatient general routine operating costs applicable to cost reporting periods beginning on or after July 1, 1981, and for cost reporting periods ending after September 30, 1981. As issued, the February 17, 1984, notice does not affect the cost limits for cost reporting periods beginning on or after October 1, 1982, because the limits for those cost reporting periods are governed by the notices published in the **Federal Register** on September 30, 1982 (47 FR 43296), and August 30, 1983 (48 FR 39426).

The proposed notice published February 17, 1984, reissued the wage index that was originally issued as part of the schedule of limits contained in notices published on June 30, 1981 (46 FR 33637), and September 30, 1981 (46 FR 48010). The latter notice contained adjustments to the limits required by section 2143 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35, enacted on August 13, 1981).

We reissued the 1981 wage index for public comment as the result of the April 29, 1983, decision of the United States District Court for the District of Columbia in the case of *District of Columbia Hospital Association, et al.* vs. *Heckler, et al.* (No. 82-2520 DDC). The District Court held that the 1981 schedule of hospital cost limits was invalid insofar as the schedule incorporated or was formulated by using a wage index that was calculated by excluding Federal Government hospital wage data. The court held that exclusion of Federal Government hospital wage data without having published the schedule for

public comment constituted a failure to comply with the Administrative Procedure Act (APA) (5 U.S.C. 553). The February 17, 1984, proposed notice was intended to remedy the rulemaking deficiencies perceived by the District Court and to validate use of the 1981 schedule of hospital cost limits by bringing the wage index contained in the 1981 schedule of limits into compliance with the APA.

II. Public Comments

In response to the February 17, 1984, proposed notice, we received comments from four hospital associations, an Indian health center, a major insurance company and a law firm representing a hospital association and its members. We received six comments favoring the exclusion of Federal hospital wage data in the calculation of the wage index. These commenters agreed that we should exclude Federal hospital wage data to improve the accuracy of the wage index. Two commenters favored the inclusion of Federal hospital wage data in the calculation of the wage index. A summary of these comments and our responses follow.

Comment—Two commenters suggested that we provide an appeals mechanism for those hospitals in areas where the exclusion of Federal hospitals from the wage index calculation produces a wage index factor that does not adequately reflect labor market forces.

Response—The rationale for excluding Federal hospital wage data from the wage index calculation is that Federal wages do not reflect the local labor market forces. If the Federal hospital wage data reflected the area's labor market, the index factor for an area would not be strongly affected by the exclusion of the Federal wage data.

A national system of cost limits presupposes that the same basic methodology will be applied to all hospitals. Therefore, in determining a wage index to be used by all

hospitals, the exclusion of Federal hospital wage data must be applied to all calculations of wage factors contained in the wage index. However, we believe it important to note that if an individual hospital in an area can demonstrate that its percentage of labor costs varies by more than ten percent from the percentage used to calculate the limits, an exception can be granted under our regulations in 42 CFR 405.460(f)(8).

In addition, it should be noted that under the existing appeals procedures, a hospital, in all instances, may protest any intermediary determination through administrative and judicial review proceedings.

Comment—One hospital association commented that the use of the Standard Metropolitan Statistical Area [SMSA/Non-SMSA] classification system does not reflect the hospital's local labor market.

Response—Since the inception of the cost limits in 1974, we have used SMSAs as the definition of urban areas because nationally accepted objective standards were needed. This method of classifying hospitals has been open for public comment since that time. The definition of SMSA was developed by the Executive Office of Management and Budget (EOMB) using population criteria and other standards such as the degree of economic and social integration among potientially [sic] qualifying counties. Currently, we know of no other nationally recognized classification system suitable for use in a national payment system. Also, we wish to note that the wage index is not intended to reflect the specific wages of one hospital but is intended to reflect general trends in the local economy.

Comment—Two commenters suggested that since including Federal hospital wage date changes the wage index factors only for a few areas, a notice of program reimbursement should be issued only when a hospital has successfully appealed its wage index.

Response—Including Federal hospital wage data would affect a large number of areas because the national

average wage would be increased by including Federal hospital wage data; however, areas without a Federal hospital will still have the same average wage. When the national average is divided by the area average, a lower index factor will result. It is our estimate that approximately 234 areas would receive lower wage index factors if Federal hospital wages were included in the wage index calculation.

Comment—One hospital association recommended that the methodology used for developing the wage index should continue to be studied.

Response—As part of our continuity efforts to refine the wage index methodology used under the prospective payment system for inpatient hospital services, we have asked each short term acute care Medicare participating hospital to complete a hospital wage survey. We hope to be able to use the information received from this survey to assess the effect of some of the technical deficiencies in the current wage index (for example, area differences in the use of part time employees) in order to determine how to develop an improved wage index methodology.

Comment—One commenter requested that we clarify whether the use of appropriate wage index values for some areas is due to a change in the Bureau of Labor Statistics (BLB) [sic] confidentiality requirements.

Response—The BLS supply us with data on wages and numbers of employees that are used to calculate the wage index. Because of BLS's confidentiality requirements, BLS could not disclose actual data for areas that included fewer than three reporting units. A reporting unit need not have been a single hospital. A reporting unit was (and is currently) defined by BLS as the smallest unit for which data are recorded on the employer's contribution report. For example, two facilities in the same area owned by one employer could have appeared as one reporting unit. Therefore, because of BLS's confidentiality requirements,

we used approximate rather than actual index values for 26 areas. These approximate values are identified by asterisks in table I-A.

Comments—One commenter believes that we should include Federal hospital wage data in the calculation of the wage index because of problems associated with averaging hospital wages in developing the wage index.

Response—The hospital wage index is designed to recognize relative differences in wage levels across the United States that reflect conditions present in local economies. The wage index is not intended to recognize the employment practices of any one institution. The reason for excluding Federal hospital wage data from the calculation of the wage index is not because of an averaging problem. We exclude Federal hospital wage data because the wages paid by a Federal hospital do not reflect the local economy since Federal wages are based primarily on national pay scales. If non-Federal hospitals are paying wages similar to Federal hospitals, this will be reflected in the area's reported quarterly hospital wages. However, if only one hospital in the area is paying high wages, the area's average will reflect this. It is possible that the hospital paying these higher costs is incurring unreasonable costs that are out of line with the costs of similar institutions. The cost limits have been established to prevent paying for costs that are unnecessary in the efficient delivery of health care services. It is our belief that wages that are out of line with similar institutions may be an indication that the hospital paying these higher wages is not being run as efficiently as other institutions in the area.

Comment—One hospital association suggested that we eliminate the lowest wage index factor in an area on a weighted average basis because Federal hospitals tend to be large and reflect a greater weight in the averaging process.

Response—By excluding Federal hospital wage data from the calculation of the wage index factors, we have

already eliminated the effect Federal hospital wages have on an area's average and on the national average.

Comment—One commenter recommended that we use a facility-specific wage index.

Response—The cost limits are based on a national system of classifying hospitals in bed size groupings and the limits are set at a percent of the mean labor-related costs and means nonlabor costs of each peer comparison group. The cost limits are used as a measure of a hospital's reasonable costs. Establishing a facility-specific index recogizes that all the wages paid at a hospital are part of its reasonable costs. A hospital may be paying wages that are unreasonable when compared to wages paid by similar providers. Recognizing these unreasonable costs as reasonable would be a violation of our responsibility to pay only those costs necessary for the efficient delivery of health care services.

Comment—One hospital association was of the opinion that eliminating Federal hospital wage data from the calculation of the wage index will lower reimbursement to facilities located around the Federal hospital.

Response—The elimination of Federal hospital wage data from the calculation of the wage index does not automatically result in lower reimbursement amounts to facilities around the Federal hospital. If a hospital's costs are under the limit, then the hospital will be reimbursed in full for its costs. We believe that the elimination of Federal hospital wage data from the calculation of the wage index gives hospitals a financial incentive to control costs within the allowed limit amount. It is our belief that the cost limits, as currently determined, more accurately reflect a hospital's reasonable costs than the use of cost limits that are artificially inflated by the use of a wage index factor that overstates the wages actually paid by hospitals in cer-

tain locales. Of course, as indicated above, if hospitals located in the same area as a Federal hospital are paying wages similar to those paid by the Federal hospital, then the index will reflect this.

Comment—A law firm representing a hospital association and its members commented that the proposed notice of February 17, 1984, is invalid under the APA because it is retroactive rulemaking.

Response—We do not consider this notice to be retroactive in nature, since as a practical matter hospitals could only have relied on the notice published on June 30, 1981, and September 30, 1981, in determining their respective cost limits for cost reporting periods beginning on or after July 1, 1982, and for cost reporting periods ending after September 30, 1981, and beginning on or after October 1, 1981. Moreover, there is substantial legal authority which permit's [sic] an agency a rule which covers an earlier period of time when it is reasonable to do so. The United States District Court for the District of Columbia did not rule that excluding Federal hospitals was an invalid methodology, but rather that we had not solicited public comments prior to making a change in methodology. At the time of the hearing, the plaintiffs in the case requested an order from the court to prevent the Secretary from republishing a wage index that excluded Federal hospital wage data. The court declined to do this. Therefore, we do not believe the ruling from the court precludes us from reissuing a wage index that excludes Federal hospital wage data. By issuing a proposed notice and final notice, we are correcting the procedural defect of not soliciting public comments before making a change in methodology. At the same time, we are not causing undue hardship to any hospital because there were no other published limits available for a hospital to use at the time of the original publication of the June 30 and September 30, 1981, notices. Each hospital knew in advance of its cost reporting period what its cost limit would be for this period. Given these circumstances and the public interest in ensuring that only those costs necessary in the efficient delivery of services be reimbursed, we believe this notice is valid.

Comment—One commenter recommended that the wage index published in the proposed notice be used for hospitals unless a hospital specifically requests a computation of its routine cost limit using a wage index that include Federal hospital wage data.

Response—The system of cost limits is to be uniformly applied to all hospitals. The use of a wage index excluding Federal hospital data for one group of hospitals and a wage index including Federal hospital data for another group would result in a two-tiered system. The use of a two-tiered system would be contrary to the principle of uniformity. In addition, it is our belief that those hospitals that would request a recomputation of the wage index to include Federal hospital wage data would be those hospitals that have exceeded the cost limits for the particular cost reporting period. As previously discussed, the cost limits are used to establish the reasonable and necessary costs for delivering efficient health care services. Recomputing the limits for those hospitals that exceeded the limits would violate the statutory requirement that we pay only those costs that are reasonable and necessary for the efficient delivery of needed health care services.

Even though only a limited number of hospitals are adversely affected by the exclusion of Federal hospital wage data, a significant amount of Medicare reimbursement is involved for each individual hospital that is affected. Since it is our belief that Federal hospital wage data do not reflect the conditions of local economies, allowing a recomputation of the wage index including Federal hospital wage data for those hospitals requesting it would result in our allowing these hospitals additional

reimbursement for costs that were not necessary in the efficient delivery of needed health care services. It would not be equitable to those hospitals that operated efficiently under the limits, for us to reward hospitals that exceeded the cost limits because they operated inefficiently.

Comment—One commenter stated that the change in the wage index does not permit hospitals sufficient time to adjust to the methodology change.

Response—We consider the change that was made to the wage index a minor technical change. It is our belief that hospitals were put on notice of this change on June 30, 1981 (46 FR 33637), when we first published the schedule of limits applicable to the affected period. The cost limits are effective at the beginning of a hospital's cost reporting period. Thus, a hospital has twelve months in which to adjust its routine inpatient operating costs to the published limits in order to receive full reimbursement for its Medicare costs. Since there were no other published limits for the affected period, the only notice a hospital could have relied on in determining its limit was the June 30, 1981, notice.

By republishing the same wage index at this time, we are correcting the procedural defect perceived by the court; that is, the failure to provide for a comment period.

Comment—One commenter noted that in a comparison of BLS data using only Federal hospital wage data for five SMSAs, there were variations in the average monthly wages reported to BLS for the Federal hospitals in each SMSA. For example, the data indicated high monthly wages in the San Francisco-Oakland, CA SMSA and low monthly wages in the Norfolk-Virginia Beach-Portsmouth, VA-NC SMSA. From this comparison, the commenter concludes that Federal hospitals do not necessarily use national wage scales.

Response—The difference in the monthly wages reported for the Federal hospitals in the SMSAs noted is not necessarily due to Federal hospitals paying local wages. We have always acknowledged that there are some technical deficiencies in the wage index that make it a less than perfect source for a wage index adjuster. For example, the data do not account for variations in hospital occupational mix, differences in the proportion of part-time employees, variations in overtime utilization, length of the work week, and differences in reporting compliance. Any one of these reasons could account for the discrepancy in average monthly wages.

We obtained the average monthly wages for the same five SMSAs but excluded Federal hospital wage data. In all five SMSAs the average monthly wages excluding Federal hospital wage data were lower than the average monthly wages for the Federal hospitals. In the Norfolk-Virginia Beach-Portsmouth, VA-NC SMSA the average monthly wage for Federal hospitals was $1,175.48 versus an average monthly wage of $865.77 not including any Federal hospitals. In the San Francisco-Oakland, CA SMSA, the average monthly wage for Federal hospitals was $1,564.75 versus an average monthly wage of $1,151.75 not including any Federal hospitals. Our comparison appears to prove our theory that Federal hospitals are not paying local wages. If the Federal hospitals were paying local wages, the average monthly wage for Federal hospitals would be the same figure as the average monthly wage not including Federal hospitals for the same SMSA.

Comment—A law firm commented that HCFA does not differentiate between urban and suburban locations within an SMSA. The commenter believes that a differentiation between urban and suburban would improve the accuracy of the wage index.

Response—In principle, using a wage index that differentiates urban (that is, "core") from suburban (that is, "ring") counties could provide a more precise wage index. However, it is our belief that the adoption of such a measure at this time is not feasible due to certain limitations of the BLS data used to construct the wage index. Although BLS data are the best data currently available that were compatible with a national payment system, it is important to note that, as previously explained, the data do contain certain technical deficiences. The BLS data do not account for differences in the proportion of part-time employees, area difference in occupational mix, variations in overtime utilization, length of the work week, and differences in reporting compliance. The current use of aggregated BLS data from all non-Federal hospitals within a specified SMSA mitigate the effect of these uncontrolled variables, particularly in large metropolitan areas with many hospitals. It is our belief that disaggregating the data into "core-ring" indexes would only magnify the inherent limitations of the BLS data and increase the potential for distortion, particularly in areas with few hospitals. The use of a "core-ring" urban wage index merits further study. However, pending the development of a data base which overcomes the techical limitations of the BLS data, we believe further wage index refinements must be deferred.

We would like to emphasize that a provider's location in an SMSA or non-SMSA has been used as a classification criterion for cost limit purposes continuously since 1974. The definitions of SMSA and New England County Metropolitan Area (NECMA) were developed by EOMB. Effective June 30, 1983, the definition of SMSA was replaced by Metropolitan Statistical Area (MSA). We do not independently determine when an area qualifies as an MSA. Rather, this determination is made by EOMB.

We believe this classification system is the only one currently available that meets the requirements of a national payment program. The SMSA (now MSA) classification is a widely accepted statistical standard developed for use by Federal agencies in the production, analysis, and publication of data on metropolitan areas. The standards were developed with the aim of producing definitions that are as consistent as possible for all SMSAs nationwide.

Comment—One Indian Health Service area representative recommended that HCFA use the general wage index for the area in which the Federal hospital is located to reimburse the Federal hospital. The commenter noted that most Indian Health Service hospitals are located in rural areas. The commenter pointed out that Indian Health Service hospitals are paid under the prospective payment system for inpatient hospital services using a wage index that is approximately 63 percent higher than the national average wage data.

Response—As stated previously, we believe Federal hospital wage data do not reflect the conditions within a local economy. Since Indian Health Service hospitals do not serve the general population of an area, and exist as a unique health care delivery system, they were included under the prospective payment system for inpatient hospital services using a single index value applicable to all Indian Health Service hospitals and specifically computed to be representative of the wage experience in the Indian Health Service system.

We wish to point out that the prospective payment system for inpatient hospital services is inherently different from the Medicare cost limits applicable in prior years in that the prospective rate determines the actual Medicare payment. Under the prior cost limit system payment was based on the costs incurred up to a maximum amount allowed by the cost limit. Because we considered it important that Indian Health Service hospitals have the

opportunity to participate in the prospective payment system for inpatient hospital services, and since they operate under a central administration, we established a single uniform wage index value for the Indian Health Service. Although the comment we received is in fact directed at an aspect of the prospective payment system for inpatient hospital services rather than the wage index issued for comment, we note that the essence of the commenter's statement is that wages in Indian Health Service hospitals will generally exceed those in the surrounding areas. We believe this comment from the Indian Health Service adds weight to our conclusion that wage levels in Federal hospitals are not usually representative of local wage conditions.

III. Changes in Reponse to Public Comments

We have decided not to recalculate the 1981 wage index to include data from Federal Government hospitals. Therefore, this notice affirms the exclusion of Federal Government hospital data from the wage index. It is our belief that the exclusion of Federal hospital data improves the accuracy of the wage index so that the index correctly reflects actual differences in wages from one area to another area. The wage index serves to reflect area-by-area differences in the labor related component of hospital costs. The more accurate the wage index, the more accurately it reflects these area-by-area differences and thus, ultimately, the more accurate are the cost limits. We conclude that the exclusion of Federal Government hospital data improves the accuracy of the wage index because most Federal hospitals characteristically employ physicians and other high salaried professionals whose salaries are based on national rather than local wage scales. This factor tends to overstate the average hospital wage in areas

with Federal institutions as compared to areas without such Federal facilities. Since the purpose of the wage index is to reflect area-by-area differences in the labor-related component of hospital costs, the exclusion of Federal hospital data better enables the wage index to reflect accurately area-by-area labor related costs.

In summary, we believe that the exclusion of Federal hospital data from the wage index reflects actual hospital experience. We wish to note that the data used to develop the wage index were supplied by BLS and are the most reliable data available. All hospitals are required under State unemployment compensation laws to report these data. However, if we discover that we or BLS have made an error based on data received from hospitals that result in an incorrect wage index for any area, we will publish corrected indexes and will direct the Medicare intermediaries to recalculate the limits for affected hospitals. However, BLS has advised us that it is unable to correct any inaccuracies in the wage index that may result from a hospital's failure to report the required wage data.

It should be noted that from the time the original schedule of limits was published in the June 30, 1981, notice BLS has advised us of various reporting errors in the wage and employment data. In addition, as noted earlier, on June 19, 1981, EOMB announced the designation of new MSAs and NECMAs, as well as other revisions in metropolitan classifications based on the results of the 1980 census. We have issued instructions to the intermediaries advising them of these changes. However, in those situations where the corrected data resulted in a lower wage index for an area, we continued to use the higher wage index. The wage indexes that are shown in Tables I-A and I-B reflect the corrections that have been made since June 30, 1981.

IV. Regulatory Impact Statement

A. Executive Order 12291 and Regulatory Flexibility Act

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for rules that are likely to have an annual effect on the economy of $100 million or more, cause a major increase in costs or prices, or meet other threshold criteria that are specified in that order. In addition, the Regulatory Flexibility Act (5 U.S.C. 601-612) requires us to prepare and publish a regulatory flexibility analysis for certain rules unless the Secretary certifies that the rules will not have a significant economic impact on a substantial number of small entities. (For purposes of the Regulatory Flexibility Act, we consider all hospitals to be small entities.) Under both the Executive Order and the Regulatory Flexibility Act, such analyses must, when prepared, show that the agency issuing the rules has examined alternatives that might minimize burden or otherwise ensure the rules to be cost-effective.

We have determined that this notice does not meet the criteria of either E.O. 12291 or the Regulatory Flexibility Act. We considered two alternatives:

- To republish an area wage index with values calculated as published in 1981 with no change in methodology; or
- To publish an area wage index with values recalculated to incorporate Federal hospitals in the base data.

We found that if we included Federal hospitals in the area wage index determinations, we would have to recalculate both urban and rural national average hospital wage levels, as well as the means used to determine the per diem limits for each group (published as Tables I and II in

the 1981 notices). This would affect the limit for every hospital subject to the limits, although only to a relatively small degree. The limits for some groups would increase, while the limits for other groups would decrease.

We determined that if we were to publish recalculated index values the net effect on overall program expenditures would be relatively small, due to the tendency of increases and decreases in group limits and index values to cancel each other out in the aggregate. A change of the area wage index to incorporate Federal hospitals in the base data would have the primary effect of redistributing marginal advantages and disadvantages. For each particular hospital, the effect of including Federal hospitals in the index data would be the result of multiplying the hospital's recalculated per diem limit for the hospital's group by the hospital's recalculated area wage index value. If both the group mean used to derive the limit applicable to a particular hospital, and the index value for that hospital were to increase or decrease, the effect of the recalculations would of course be compounded. If the change in the limit and the index were in opposite directions, however, they would tend to cancel each other out.

Including Federal hospital wage data would benefit only those few hospitals located in areas with Federal hospital employees, which would have higher index values as a result, and generally would disadvantage all those hospitals not located in such areas. Many Medicare participating hospitals could be adversely affected, since about 234 areas would have lower wage index values. However, the impact on the majority of individual hospitals would be relatively small.

In the aggregate, the reissuance of an area wage index excluding Federal hospitals will—

- Generally affect the annual Medicare revenues of individual hospitals by small amounts, compared to their total revenues;

• Have little net effect on aggregate hospital revenue from Medicare;
• Be more cost beneficial to hospitals as a whole;
• Have little or no effect on costs or prices; and
• Result in a smaller net disadvantage to hospitals as a whole.

In conclusion, the use of the wage index methodology as initially published in 1981 does not meet any of the criteria for identifying a major rule under E.O. 12291, and we have determined that this notice is a not a major rule and that a regulatory impact analysis is not required. In addition, the Secretary certifies under section 5 U.S.C. 605(b) of the Regulatory Flexibility Act, that this notice will not result in a significant economic impact on a substantial number of small entities, and that a regulatory flexibility analysis is not required.

B. Paperwork Burden

This notice contains no information collection requirements and, therefore, is not subject to review by EOMB under the Paperwork Reduction Act of 1980 (44 U.S.C. 3507).

VI. Wage Index Tables

TABLE I-A.—WAGE INDEX FOR URBAN AREAS

SMSA area	Wage index
Abilene, TX	0.8485
Akron, OH	1.0417
Albany, GA	.8566
Albany-Schenectady-Troy, NY	.9624
Albuquerque, NM	1.0009
Alexandria, LA	[5].9218
Allentown-Bethlehem-Easton, PA-NJ	1.0569
Altoona, PA	1.0219
Amarillo, TX	.9233
Anaheim-Santa Ana-Garden Grove, CA	1.2115
Anchorage, AK	1.6461
Anderson, IN	.9812

* * *

[remainder of tables not reproduced]

(Secs. 1102, 1814(b), 1861(v)(1), 1866(a), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395x(v)(1), 1395cc(a), 1395hh; and 42 CFR 405.460)

* * *

Dated: September 21, 1984

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: October 30, 1984.

Margaret M. Heckler,

Secretary.

Medicare
Group Hospitalization, Inc. serves as Intermediary for Medicare Part A in the Washington, D.C. metropolitan area

Blue Cross
Group Hospitalization, Inc.
550 12th Street, S.W.
Washington, D.C. 20024
202/479-8000

March 12, 1985

Mr. Charles O'Brien
Administrator
Georgetown University Hospital
3800 Reservoir Road, N.W.
Washington, D.C. 20007

RE: Notice to Reopen and Correct Medicare Cost Report for the Fiscal Year Ended June 30, 1982

Dear Mr. O'Brien:

In accordance with Medicare Regulation No. 5—Subpart R, Sections 405.1885 and 405.1887, notice is hereby given that the above referenced cost report is to be reopened. Your routine cost limit report on Schedule D-1 has been revised to exclude federal hospital wages in its wage index. This is based on a reversal of the original United States District Court decision in Case No. 82-2526 (District of Columbia Hospital Association vs. Heckler) in which the court ruled that federal hospital wages should be included in the wage index. Notice of this change is published in the November 26, 1984 Federal Register Vol. 49, No. 228 and is effective December 26, 1984.

As a result of this decision, your routine cost limit has decreased from $171.96 to $167.24, resulting in an overpayment of $218,074 in cost reimbursement. A revised

Notice of Program Reimbursement will be issued in the near future requesting repayment of this amount.

If you are dissatisfied with the adjustments made as a result of this reopening and wish to appeal, any request for an appeal must be made in writing within 180 days from the date of the corrected final notice of program reimbursement in accordance with Regulation 405.1811 and/or 405.1841. For your information, the original notice of program reimbursement was dated June 29, 1984.

Please let me know if you have any questions concerning this notice.

Sincerely,

/s/ R. M. HUGNEY

R. M. Hugney
Staff Assistant
Provider Reimbursement

Medicare
Group Hospitalization, Inc. serves as Intermediary for Medicare Part A in the Washington, D.C. metropolitan area

Blue Cross
Group Hospitalization, Inc.
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Dear Mr. O'Brien:

In accordance with Medicare Regulation No. 5—Subpart R, Sections 405.1885 and 405.1887, notice is hereby given that the above referenced cost report is to be reopened. Your routine cost limit report on Schedule D-1 has been revised to exclude federal hospital wages in its wage index. This is based on a reversal of the original United States District Court decision in Case No. 82-2526 (District of Columbia Hospital Association vs. Heckler) in which the court ruled that federal hospital wages should be included in the wage index. Notice of this change is published in the November 26, 1984 Federal Register Vol. 49, No. 228 and is effective December 26, 1984.

As a result of this decision, your routine cost limit has decreased from $187.08 to $181.93, resulting in an overpayment of $223,881 in cost reimbursement. A revised Notice of Program Reimbursement will be issued in the near future requesting repayment of this amount.

If you are dissatisfied with the adjustments made as a result of this reopening and wish to appeal, any request for an appeal must be made in writing within 180 days from the date of the corrected final notice of program reimbursement in accordance with Regulation 405.1811 and/or 405.1841. For your information, the original notice of program reimbursement was dated June 27, 1984.

Please let me know if you have any questions concerning this notice.

Sincerely,

/s/ R. M. HUGNEY
R. M. Hugney
Staff Assistant
Provider Reimbursement

**H.R. Rep. No. 92-231, 92d Cong.,
1st Sess. 82-85 (1971) (excerpts)**

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* * * * *

[82] (*c*) *Limitations on coverage of costs under medicare.* – Your committee is mindful of the fact that costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of services provided, the type of patient treated, the location of the institution and various other factors affecting the efficient delivery of needed health services. Your committee is also aware, however, that costs can vary from one institution to another as a result of variations in efficiency of operation, or the provision of amenities in plush surroundings. Your committee believes that it is undesirable from the standpoint of those who support Government mechanisms for financing health care to reimburse health care institutions for costs that flow from marked inefficiency in operation or conditions of excessive service.

[83] To the extent that differences in provider costs can be expected to result from such factors as the size of the institution, patient mix, scope of services offered or other economic factors, wide, but not unlimited recognition should be given to the variations in costs accepted as reasonable. However, data frequently reveals wide variations in costs among institutions that can only be attributable to those elements of costs that would ordinarily not be expected to vary substantially from one institution to another.

Where the high costs do in fact flow from the provision of services in excess of or more expensive than generally considered necessary to the efficient provision of appropriate patient care, patients may nevertheless desire such services. It is not the committee's view that if patients

desire unusually expensive service they should be denied the service. However, it is unreasonable for medicare or medicaid (which are financed by almost all people in the country rather than the patient or community that wants the expensive services) to pay for it.

Similarly when the high costs flow from inefficency in the delivery of needed health care services the institution should not be shielded from the economic consequences of its inefficiency. Health care institutions, like other entities in our economy should be encouraged to perform efficiently and when they fail to do so should expect to suffer the financial consequences. Unfortunately a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

Present law provides authority to disallow incurred costs that are not reasonable. However, there are a number of problems that inhibit effective exercise of this authority. The disallowance of costs that are substantially out of line with those of comparable providers after such costs have been incurred creates financial uncertainty for the provider, since, as the system now operates, the provider has no way of knowing until sometime after it incurs expenses whether or not they will be in line with expenses incurred by comparable providers in the same period. Furthermore, present law generally limits exercise of the authority to disallow costs to instances that can be specifically proved on a case-by-case basis. Clear demonstration of the specific reason that a cost is high is generally very difficult. And, since a provider cannot charge a beneficiary more than the program's deductible and coinsurance amounts for covered services, exercise of

either type of authority can leave the provider without reimbursement for some costs of items or services it has already incurred for patients treated some time ago. Under these circumstances the provider would have to obtain funds from some other source to make up for its deficit.

The proposed new authority to set limits on costs recognized for certain classes of providers in various service areas differs from existing authority in several ways and meets these problems. First, it would be exercised on a prospective, rather than retrospective, basis so that the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable. Second, the evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and a presumptive basis—relatively high costs [84] that cannot be justified by the provider as reasonable for the results obtained would not be reimbursable—so that implementation of the proposed authority would appear more feasible than present authority. Third, since the limits would be defined in advance, provision would be made for a provider to charge the beneficiary for the costs of items or services in excess of or more expensive than those that are determined to be necessary in the efficient delivery of needed health services. Public notice would be provided where such charges are imposed by the institution and the beneficiary would be specifically advised of the nature and amount of such charges prior to admission so that there is opportunity for the public, doctors, and their medicare patients to know what additional payment would have to be made. Your committee expects that the provision will not be applicable where there is only one hospital in a community—that is, where, if the provision were applied, additional charges could be imposed on beneficiaries who have no real opportunity to use a less

expensive, non-luxury institution, and where the provision would be difficult to apply because comparative cost data for the area are lacking.

Your committee recognizes that the initial ceilings imposed will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. And your committee recognizes that these provisions will apply to a relatively quite small number of institutions. The data that are available for this purpose will often be less than perfectly reliable—for example, it may be necessary to use unaudited cost reports or survey or sampling techniques in estimating the costs necessary to the efficient delivery of care. Under medicare's administrative system, however, cost reports prepared by the providers are now being submitted more promptly after the close of the accounting period and should be available for analysis in the next year and for the establishment of limits in the second following year. Also, the precision of the limits determined from these data will vary with the degree to which excessive costs can be distinguished from the provision of higher quality or intensity of care.

For costs that would not generally be expected to vary with essential quality ingredients and intensity of medical care—for example, the costs of the "hotel" services (food and room costs) provided by hospitals—the Secretary might set limits sufficiently above the average costs per patient day previously experienced by a class of hospitals to make allowance for differing circumstances and short-term economic fluctuations. Hotel services may be easiest to establish limits for and be among the first for which work can be completed. Attention might be given as well to laundry costs, medical record costs, and administration costs within the reasonably near future.

Setting limits on overall costs per patient day and specific costs that vary with the quality and intensity of

care would be more difficult, but the Secretary might be able to set reasonable limits sufficiently above average costs per patient day previously experienced by a class of institutions so that only cases with extraordinary expenses would be subject to any limits. In addition, special limits could be established on cost elements found subject to abuse. For example, the Secretary might establish limits on the level of standby costs that would be recognized as reasonable under the program to prevent Government programs from picking up the cost of excessive amounts of idle capacity—particularly relatively high personnel costs in relation [85] to patient loads where occupancy rates are low—in reimbursing for services to covered patients.

Providers would, of course, have the right to obtain reconsideration of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception.

Providers will be permitted to collect costs in excess of the medicare ceilings from the beneficiary (except in the case of admission by a physician who has a direct or indirect financial interest in a facility) where these costs flow from items or services in excess of or more expensive than those necessary for the effective delivery of needed services, provided all patients are so charged and the beneficiary is informed of his liability in advance. Information on additional charges assessed would also be made available generally in the community. Your committee is also requesting that the Secretary submit annually to it a report identifying the providers that make such additional charges to beneficiaries and furnishing information on the amounts being charged by such providers.

The determination of the cost of the excess items or services for which the beneficiary may be charged will be

made on the basis of costs previously experienced by the provider. For example, if costs for food services experienced in 1969 among a group of hospitals in an area ranged from $4 to $9 a day with a median cost of $5 a day and the limit for food services set by the Secretary for 1971 was $7.20 a day, the hospital previously experiencing costs of $9 a day could charge patients $1.80 a day for food services. However, should total reimbursement for covered services from the program plus charges billed for such services exceed actual costs in any year, the excess will be deducted from payments to the provider. Thus, the provider would not profit from charges to beneficiaries based on excess costs in the prior year.

In addition it should be noted that the fact that a provider's costs are below the ceilings established under this provision will not exempt it from application of the ceiling of customary charges where such charges are less than cost under another provision in the committee bill.

The provision would be effective with respect to accounting periods beginning after June 30, 1972.

* * * * *

S. Rep. No. 91-1230, 92d Cong.,
2d Sess. 187-190 (1972) (excerpts)

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[187] **Limitations on Coverage of Costs Under Medicare**
(Sec. 223 of the bill)

The committee is mindful of the fact that costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of services provided, the type of patient treated, the location of the institution and various other factors affecting the efficient delivery of needed health services. The committee is also aware, however, that costs can vary from one institution to another as a result of variations in efficiency of operation, or the provision of amenities in plush surroundings. The committee believes that it is undesirable from the standpoint of those who support Government mechanisms for financing health care to reimburse health care institutions for costs that flow from marked inefficiency in operation or conditions of excessive service.

To the extent that differences in provider costs can be expected to result from such factors as the size of the institution, patient mix, scope of services offered or other economic factors, wide, but not unlimited recognition should be given to the variations in costs accepted as reasonable. However, data frequently reveals wide variations in costs among institutions that can only be attributable to those elements of cost that would ordinarily not be expected to vary substantially from one institution to another.

Whether the high costs do in fact flow from the provision of services substantially in excess of or more expensive than generally considered necessary to the efficient provision of appropriate patient care, patients may nevertheless desire such services. It is not intended that patients

who desire unusually expensive service should be denied the service. However, it is unreasonable for medicare or medicaid (which are financed by almost all people in the country rather than the patient or community that wants the expensive services) to pay for it.

Similarly when the high costs flow from inefficiency in the delivery of needed health care services the institution should not be shielded from the economic consequences of its inefficiency. Health care institutions, like other entities in our economy should be encouraged to perform efficiently and when they fail to do so should expect to suffer the financial consequences. Unfortunately a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. The committee believes that the objectives can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

[188] Present law provides authority to disallow incurred costs that are not reasonable. However, there are a number of problems that inhibit effective exercise of this authority. The disallowance of costs that are substantially out of line with those of comparable providers after such costs have been incurred creates financial uncertainty for the provider, since, as the system now operates, the provider has no way of knowing until sometime after it incurs expenses whether or not they will be in line with expenses incurred by comparable providers in the same period. Furthermore, present law generally limits exercise of the authority to disallow costs to instances that can be specifically proved on a case-by-case basis. Clear demonstration of the specific reason that a cost is high is generally very difficult. And, since a provider cannot charge a beneficiary more than the program's deductible

and coinsurance amounts for covered services, exercise of either type of authority can leave the provider without reimbursement for some costs of items or services it has already incurred for patients treated some time ago. Under these circumstances the provider would have to obtain funds from some other source to make up for its deficit.

Accordingly, the committee has approved a provision in the House bill which would authorize the Secretary of Health, Education, and Welfare to set limits on costs recognized as reasonable for certain classes of providers in various service areas. This authority differs from existing authority in several ways and meets these problems. First, it would be exercised on a prospective, rather than retrospective, basis so that the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable. Second, the evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and a presumptive basis—relatively high costs that cannot be justified by the provider as reasonable for the result obtained would not be reimbursable—so that implementation of the proposed authority would appear more feasible than present authority. Third, since the limits would be defined in advance except with respect to emergency care, provision would be made for a provider to charge the beneficiary for the costs of items or services substantially in excess of or more expensive than those that are determined to be necessary in the efficient delivery of needed health services. Public notice would be provided where such charges are imposed by the institution and the beneficiary would be specifically advised of the nature and the amount of such charges prior to admission so that there is opportunity for the public, doctors, and their medicare patients to know what additional payment would have to be made.

The committee expects that the provision will not be applicable where there is only one hospital in a community—that is, where, if the provision were applied, additional charges could be imposed on beneficiaries who have no real opportunity to use a less expensive, nonluxury institution, and where the provision would be difficult to apply because comparative cost data for the area are lacking.

The committee, along with the Committee on Ways and Means, recognizes that the initial ceilings imposed will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. And the committee recognizes that these provisions [189] will apply to a relatively quite small number of institutions. The data that are available for this purpose will often be less than perfectly reliable—for example, it may be necessary to use unaudited cost reports or survey or sampling techniques in estimating the costs necessary to the efficient delivery of care. Under medicare's administrative system, however, cost reports prepared by the providers are now being submitted more promptly after the close of the accounting period and should be available for analysis in the next year and for the establishment of limits in the second following year. Also, the precision of the limits determined from these data will vary with the degree to which excessive costs can be distinguished from the provision of higher quality or intensity of care.

For costs that would not generally be expected to vary with essential quality ingredients and intensity of medical care—for example, the costs of the "hotel" services (food and room costs) provided by hospitals—the Secretary might set limits sufficiently above the average costs per patient day previously experienced by a class of hospitals to make allowance for differing circumstances and short-term economic fluctuations. Hotel services may be easiest

to establish limits for and be among the first for which work can be completed. Attention might be given as well to laundry costs, medical record costs, and administration costs within the reasonably near future.

Setting limits on overall costs per patient day and specific costs that vary with the quality and intensity of care would be more difficult, but the Secretary might be able to set reasonable limits sufficiently above average costs per patient day previously experienced by a class of institutions so that only cases with extraordinary expenses would be subject to any limits. In addition, special limits could be established on cost elements found subject to abuse. For example, the Secretary might establish limits on the level of standby costs that would be recognized as reasonable under the program to prevent Government programs from picking up the cost of excessive amounts of idle capacity—particularly relatively high personnel costs in relation to patient loads where occupancy rates are low—in reimbursing for services to covered patients.

Providers would, of course, have the right to obtain reconsideration of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception.

For other than emergency care, providers will be permitted to collect costs in excess of the medicare ceilings from the beneficiary (except in the case of admission by a physician who has a direct or indirect financial interest in a facility) where these costs flow from items or services substantially in excess of or more expensive than those necessary for the effective delivery of needed services, provided all patients are so charged and the beneficiary is informed of his liability in advance. Information on additional charges assessed would also be made available generally in the community. The committee is also requesting that the Secretary submit annually to it a report identifying the providers that make such additional charges to beneficiaries and furnishing information on the amounts being charged by such providers.

[190] The determination of the cost of the excess items or services for which the beneficiary may be charged will be made on the basis of cost previously experienced by the provider. For example, if costs for food services experienced in 1969 among a group of hospitals in an area ranged from $4 to $9 a day with a median cost of $5 a day and the limit for food services set by the Secretary for 1971 was $7.20 a day, the hospital previously experiencing costs of $9 a day could charge patients $1.80 a day for food services. However, should total reimbursement for covered services from the program plus charges billed for such services exceed actual costs in any year, the excess will be deducted from payments to the provider. Thus, the provider would not profit from charges to beneficiaries based on excess costs in the prior year.

In addition it should be noted that the fact that a provider's costs are below the ceilings established under this provision will not exempt it from application of the ceiling of customary charges where such charges are less than cost under another provision in the committee bill.

The provision would be effective with respect to accounting periods beginning after December 31, 1972.

* * * * *

¶ 31,645 HFCA ADMINISTRATOR DECISION – LIMITATION ON REIMBURSABLE COSTS – ACCOUNTING FOR LABOR/DELIVERY ROOM DAYS

HFCA Deputy Administrator Decision, Nov. 7, 1981. *Beth Israel Hospital (Boston, Mass.) v. Blue Cross Assoc./Blue Cross/Blue Shield of Massachusetts.*

* * *

This case is before the Deputy Administrator, Health Care Financing Administration, for review of the decision entered by the Provider Reimbursement Review Board. The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act, as amended [42 USC 1395oo(f)]. Comments were received from the Intermediary requesting reversal of the Board's decision as to Issue No. 3 and from the Bureau of Program Policy requesting affirmation of Issue No. 1 and reversal of Issue No. 2. The provider submitted comments requesting reversal of Issue No. 1 and affirmation of Issue Nos. 2 and 3. Accordingly, the case is now before the Deputy Administrator for final administrative decision.

The Issues

Issue No. 1 – Bed size category

The Board held that although the provider increased the number of its available beds to over 405 during its 1976 cost year, the number of beds available on the first day of the cost year determined the providers' classification for purposes of the routine cost limitation under 42 CFR 405.460 to be in the 100-404 bed size category for the entire cost reporting period ending September 25, 1976.

Issue No. 2 – Extraordinary Circumstance Exception

The Board held that the opening of a new addition to the provider's facility was an extraordinary circumstance beyond the provider's control and supported an exception to the routine cost limits under 42 CFR 405.460(f)(3) for the cost reporting period ending September 25, 1976.

* * *

Summary of Bureau of Program Policy's Comments

Issue No. 1, the Bureau of Program Policy commented through its Division of Health Care Cost Containment, had been decided properly by the Board in accordance with established policy. In response to a request for additional clarifying information on this issue, the Division commented that Medicare policy required the cost limits to be applied prospectively. This follows the congressional intent expressed in the Senate Finance Committee Report that accompanied § 223 of P.L. 92-603. The intent is for the provider to know in advance the limits and have the opportunity to avoid having unreimbursed costs.

Accordingly, 42 CFR 405.460(a) directed the limits to be imposed prospectively. § 2510.5 of the *Provider Reimbursement Manual* therefore, requires a provider's bedsize category to be determined on the first day of the cost reporting period.

As to *Issue No. 2*, the Division recommended reversal, because the provider did not satisfy the conditions set forth in *BCA Administrative Bulletin* No. 1185 for an extraordinary circumstance exception. Further, the Board's decision on this issue goes well beyond the intent of 42 CFR 405.460(f)(3) which is to protect providers from events unrelated to their own decisions.

* * *

Summary of Provider's Comments

Concerning *Issue No. 1*, the provider requested reversal of the Board's decision, noting that for almost two-thirds of its cost year, its bed size exceeded 404 beds. The Medicare statute does not mandate that cost limits be imposed prospectively, and a recent amendment to 42 CFR 405.460(a) eliminated the language that the cost limits be imposed prospectively. Further, 42 CFR 405.460(f) authorizes departures from prospectivity by making provisions for exceptions.

The prospective nature of the limits is not weakened by the reclassification of a provider experiencing a significant change in bed size during its cost year. The criteria for setting the limits and the limits themselves are established prior to the cost reporting period. The criteria and limits do not change. This is all that § 405.460(a) and prospectivity require. When a provider's circumstances change signficantly after the start of its cost year, a new limit should be computed, consistent with the applicable criteria, to be applied prospectively for the remainder of the year.

Concerning *Issue No. 2*, the provider urged affirmation of the Board's decision, writing that the purpose of the extraordinary circumstances exception is to relieve providers from the operation of the cost limits to the extent that unusual circumstances prevent them from avoiding excessive costs. The opening of the provider's new building was such an unusual event. "A retroactive corrective adjustment" is required to reimburse the provider its reasonable costs.

The provider questioned the Intermediary's reliance on *BCA Administrative Bulletin* No. 1185, which limits new

construction exceptions to loss of licensure situations. That bulletin is unsupported by law and regulations and was never promulgated pursuant to the *Administrative Procedure Act*. As there is no rational basis to distinguish construction costs incurred due to orderly renovation from those incurred due to a threatened loss of licensure, HCFA's policy is arbitrary and capricious.

* * *

Laws and Regulations

[The "Laws and Regulations" portion of the Administrator's decision has been omitted. It contained excerpts from the following: Regulation §§ 405.460(a) (¶ 7515), 405.460(e) (¶ 7515), 405.460(f)(l) (¶ 7515), 405.460(f)(3) (¶ 7515); *Provider Reimbursement Manual* (HIM-15) § 2345 (¶ 6894) and (HIM-15) § 2510.5 (¶7531E); and *BCA Administrative Bulletin* No. 1185.]

Discussion and Evaluation

All the evidence which was furnished by the Provider Reimbursement Review Board has been considered, including all position papers and exhibits submitted by the parties. The Board's decision, having been rendered, at the request of the parties, without an oral hearing, has been carefully reviewed. The comments received after the Board issued its decision have been considered. The statement of facts set forth by the Board is incorporated by reference.

Issue No. 1 – Bed size category

By enacting Sec. 223 of P.L. 92-603 [codified in 42 USC 1395x], Congress authorized the Secretary of Health and

Human Services to prescribe regulations establishing limits on the coverage of costs reimbursable by Medicare. Pursuant to this authorization, 42 CFR 405.460 was issued to limit Medicare reimbursement to those costs considered necessary in the efficient delivery of needed health services. One of the factors to be considered under this regulation is the size of the institution to which the cost limits apply. Size is measured by the number of available beds. Prior to the beginning of a cost period, the Secretary publishes a notice in the *Federal Register* specifying the dollar amount of the cost limit to be applied during that cost period for each of the various categories of providers.

This notice is published prior to the cost period to effectuate legislative intent. That intent was expressed in the Report of the Senate Committee on Finance which accompanied P.L. 92-603. This report stated: "First, [the cost limit] would be exercised on a prospective, rather than retrospective, basis so that the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable."

In furtherance of this Congressional intent, §2510.5 of the *Provider Reimbursement Manual* (HIM-15) was developed to require a provider's bed size category to be determined "as of the first day of the pertinent cost reporting period."

The intent of Congress on reclassification to the cost limits is shown in the Senate Finance Committee Report. "Providers would, of course, have the right to obtain reconsideration of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." (S. Rep. No. 1230, 92nd Cong., 2d Sess. 188 (1972)).

Under 42 CFR 405.460(e), the provider is entitled to request a review of its classification for purposes of applying the cost limits. 42 CFR 405.460(f)(1) permits a reclassification if the provider's classification is at variance with the criteria specified in the *Federal Register* notice establishing cost limits for each year. This regulation does not preclude a reclassification based on events occurring during the cost year.

The provider had 367 beds available on the first day of its cost reporting period ending September 25, 1976. Therefore, the provider was classified in the 100-404 bed size category. In this category, the provider was entitled to a routine per diem cost limit of $115.43. On February 16, 1976, the provider's bed size increased to over 404 beds, due to the opening of a new building. At that time, 223 days remained in the provider's 1976 cost reporting period. The provider's bed size increased from 367 beds to 412 beds, a net gain of 45 beds. The routine per diem cost limit in the 405-684 bed size category during the cost year at issue was $138.13.

Having exceeded the cost limit based on 367 beds, the provider sought a reclassification to the 405-684 bed size category. This reclassification was denied. The denial was based on § 2510.5 of HIM-15 and the general policy to apply cost limits prospectively.

It is the opinion of the Deputy Administrator that the literal application of § 2510.5 in a situation such as this is not required by law or Congressional intent. When an event occurs during the cost year that both changes a provider's eligibility for a new classification and significantly increases the provider's costs, a reclassification would not violate prospectivity. The criteria for setting the limits and the limits themselves would be established for all

categories prior to the cost reporting period. The criteria and the limits would not change during that period. This is all that prospectivity requires under the circumstances in this case.

The Deputy Administrator notes that the provider's increase in bed size was substantial: 45 beds, approximately a 12% increase, and that the increase existed over 61% of the cost year at issue. Such an increase for such a period can be expected to have significantly affected the provider's per diem costs. Accordingly, it is the Deputy Administrator's opinion that the provider is entitled to be classified in the 405-684 bed size category for the cost year at issue.

Issue No. 2—Extraordinary Circumstance Exception

Under 42 CFR 405.460(f), an exception to the cost limits may be granted upon the provider's demonstration that certain conditions are present. 42 CFR 405.460(f)(3) authorizes an exception when a provider experiences substantial increased costs attributable to extraordinary circumstances beyond a provider's control. Examples given in this regulation of unusual occurrences which may give rise to this exception are "strikes, fire, earthquake, [or] flood." The regulation recognizes that "similar unusual occurrences" also may constitute an extraordinary circumstance.

The provider has sought an exception under this regulation for the increased costs of depreciation, interest, nursing, housekeeping, and maintenance incurred as a result of opening a new, 8-story, inpatient addition to the hospital. This exception was sought as an alternative to Issue No. 1 as a basis for relief from the cost limits.

The provider contends that the opening of a major addition to the hospital was an extraordinary circumstance giving rise to an exception. It is the Deputy Administrator's opinion, however, that the provider's contentions are not persuasive, because a key requirement for this exception is that the extraordiary circumstance be beyond the control of the provider.

Such absence of control is clearly lacking in this case. The provider applied to the State of Massachusetts for a certificate of need to construct the addition. The provider obtained financing through a public bond issuance for the project. The provider established a timetable in conjunction with the architects and the construction company engaged by the provider to carry out the project. The exception under 42 CFR 405.460(f)(3) was not intended for a situation where the provider exercised this degree of control.

Further, the opening of the addition is not an event similar to the specific unusual occurrences listed in the regulation. Those specific occurrences establish a frame of reference against which other circumstances may be measured. The four listed occurrences are catastrophes or events otherwise detrimental to a provider. The provider's opening of its addition was clearly not a detrimental event.

The provider questioned, as without rational justification, the Program's denial of this exception in light of the policy to permit an exception when new construction is undertaken in response to a threatened loss of licensure or accreditation. The Deputy Administrator believes the two situations are clearly distinguishable. Threat of a loss of licensure or accreditation is often beyond the provider's control. To adopt the provider's contentions would effectively destroy the incentive to control costs relating to new

construction. Accordingly, the provider is not entitled to an extraordinary circumstance exception.

* * *

Findings of Fact

1. The amounts in controversy exceed $10,000 for each of the provider's cost reporting periods ending September 25, 1976; September 24, 1977; and September 30, 1978.

2. The provider is a non-profit, general, acute-care, teaching hospital affiliated with Harvard University.

Issue No. 1—Bed size category

3. On September 28, 1975, the first day of the provider's cost reporting period ending September 25, 1976, the provider had a bed complement of 367 beds (Stipulation of Facts (SF, p. 4)).

4. Between February 4 and February 26, 1976, the provider opened a new 176-bed inpatient addition to the hospital while closing 131 beds in the old building, for a net increase of 45 beds (SF, p. 4).

5. On February 16, 1976, when 233 days remained in the provider's 1976 cost reporting year, the provider's bed capacity for the first time exceeded 404 beds (SF, p. 4).

6. Throughout the provider's 1976 cost reporting year, the provider was a Group I hospital located in a Standard Metropolitan Statistical Area (SMSA) (SF, p. 7).

7. During the 1976 cost reporting year, SMSA Group I hospitals were classified into the following categories for cost limit purposes:

Less than 100
100 to 404
405 to 684
685 and above (SF, p. 7-8).

8. The hospital inpatient general routine service cost limit for a Group I SMSA hospital in the 100 to 404 bed size category, adjusted for a cost reporting period beginning October 1, 1975, was $115.43 per diem. In the 405 to 684 bed category, it was $138.31 (SF, p. 7-8).

9. The provider's audited routine service cost per diem for its FYE September 25, 1976, was $133.33 (SF, p. 9).

10. HCFA granted the provider adjustments to its routine cost limit for atypical intern and resident costs ($13.73 per diem) and extraordinary malpractice insurance costs ($1.71 per diem) (SF, p. 11).

Issue No. 2—Extraordinary Circumstance Exception

11. Findings No. 1 through 10 above are relevant to and incorporated as Findings also as to Issue No. 2.

12. In 1971, the provider applied to the Massachusetts Department of Public Health for, and received in 1972, a certificate of need to construct an $18,725,000 eight-story inpatient addition to the hospital to be known as the Feldberg Building (SF, p. 3 & 4).

13. In 1973, construction was started on the Feldberg Building under a timetable established by the provider that planned for occupancy of the building in January 1976 (SF, p. 3).

14. Construction followed the three-year timetable laid out by the provider, and occupancy began in February 1976 (SF, p. 13-14).

15. During the provider's 1976 cost year, the provider incurred additional inpatient routine service costs of $6.89 per diem attributable to operations in the new beds in the Feldberg Building (SF, p. 14).

16. The Feldberg Building was not constructed for the purpose of maintaining licensure, JCAH accreditation, or Medicare certification.

* * *

Conclusions of Law

Issue No. 1—Bed size category

1. The provider's claimed Medicare reimbursement for routine per diem costs is subject to limitation under Sec. 1861(v)(1)(A) of the Social Security Act, as amended [42 USC 1395x] and 42 CFR 405/460(a).

2. Having experienced a substantial increase in its bed-size for a significant portion of its 1976 cost year, the provider was entitled to a reclassification of its bed-size category for routine cost limit purposes under 42 CFR 405.460(f)(1).

Issue No. 2—Extraordinary Circumstances Exception

3. The provider's opening of a new 176-bed inpatient addition to the hospital during its 1976 cost year was not beyond the control of the provider within the meaning of 42 CFR 405.460(f)(3).

4. The opening of a new 176-bed inpatient building by the provider does not constitute an "extraordinary circumstance" under 42 CFR 405.460(f)(3).

5. The provider is not entitled to an exception to the routine cost limits due to the opening of its Feldberg Building under 42 CFR 405.460(f)(3).

6. The provider's opening of a new 176-bed inpatient addition to the hospital was not an unusual occurrence similar to a strike, fire, earthquake, or flood, under 42 CFR 405.460(f)(3).

* * *

Decision

Issue No. 1

The decision of the Provider Reimbursement Review Board is reversed. The provider is entitled to be classified in the 405-684 bed size category for its cost reporting period ending September 25, 1976.

Issue No. 2

The decision of the Provider Reimbursement Review Board is reversed. The provider is not entitled to an "extraordinary circumstance" exception to the routine cost limits for its cost reporting period ending September 25, 1976.

* * *

This Constitutes the Final Administrative Decision of the Secretary of Health and Human Services.

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43 Fed. Reg. 25873 (1978)

MEDICARE PROGRAM

Extension of Grace Period for Recently Reclassified Hospitals

AGENCY: Health Care Financing Administration (HCFA), HEW.

ACTION: Notice.

SUMMARY: This notice provides an additional 1-year grace period for all hospitals that received the grace period for reclassified hospitals for cost reporting periods beginning on or after July 1, 1977 but before July 1, 1978.

EFFECTIVE DATE: This notice will become effective July 1, 1978.

FOR FURTHER INFORMATION CONTACT:
Bill Goeller, 301-594-9820.

SUPPLEMENTARY INFORMATION: A schedule of Medicare limits is promulgated each year. For cost reporting periods beginning on or after July 1, 1976 (schedule published on June 30, 1976 at 41 FR 26992), we have allowed a 1-year grace period for hospitals that are reclassified into a lower group because of a relative decline in the per capita income of the hospital's area or a change in the area's SMSA/SCSA designation. By virtue of this grace period, a reclassified hospital is subject to the higher of (a) the current limit of the group in which it is currently classified or (b) the current limit of the group in which it was classified in the immediately preceding cost reporting year. The purpose of this grace period is to "lessen the effect of unusual short-term fluctuations in area per capita income and the impact of such fluctuations on reimbursement of individual providers." The 1-year grace period provision was retained in the schedule of limits for cost reporting periods

beginning on or after July 1, 1977 (published on July 8, 1977 at 42 FR 35495) and the schedule of limits for cost reporting periods beginning on or after October 1, 1977 (published on October 3, 1977 at 42 FR 53675).

We have received many comments suggesting that a 1-year grace period does not allow a hospital adequate time to adapt its operation to the limits of the lower group. We recognize that accommodation to a lower cost level may require adjustment of staff schedules and purchasing practices that is hard to accomplish quickly. Accordingly, pending further review of this matter, we have decided to, and hereby do, extend the grace period for an additional year for those hospitals that have received the grace period for cost reporting years beginning on or after July 1, 1977 but before July 1, 1978.

The following example illustrates the effect of this rule:

Example. Hospital A's cost reporting period begins on July 1. On July 1, 1976, it was classified in Group II. On July 1, 1977 and again on July 1, 1978, it was classified in Group III, for its cost reporting year beginning July 1, 1978, Hospital A will be subject to the higher of the current Group II or the current Group III limit.

We find good cause for dispensing with opportunity for public comment and for making this policy effective July 1, 1978. It is needed to assure that hospitals not experience unnecessary hardship from a recent reclassification. It does not prejudice any hospital but provides a benefit (which we believe to be in the public interest) for a substantial number of recently reclassified hospitals.

(Secs. 1102, 1861(v)(1), 1866(a), and 1871 of the Social Security Act: 49 Stat. 647; 79 Stat. 322; 79 Stat. 327; 79 Stat. 331; 86 Stat. 1393; 42 U.S.C. 1302, 1395x(v)(1), 1395cc(a) and 1395hh.)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare – Hospital Insurance.)

Dated: May 26, 1978.

William D. Fullerton,
Acting Administrator, Health Care Financing Administration.

Approved: June 8, 1978.

JOSEPH A. CALIFANO, JR.,
Secretary.

[FR Doc. 78-16365 Filed 6-14-78; 8:45 am]

Supreme Court of the United States

No. 87-1097

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

GEORGETOWN UNIVERSITY HOSPITAL, ET AL.

ORDER ALLOWING CERTIORARI. Filed February 29, 1988

The petition herein for a writ of certiorari to the United States Court of Appeals for the District of Columbia Circuit is granted.

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